argus
a subsidiary of Aflac

Adverse Incident Report Form

Person Completing Form:

Name:	
Department:	Phone Number:

Reporting Provider (if applicable)

Name:		
Title (MD, DO, ARNP, PA, etc.):		
Specialty:		
Address:		
City:	State:	Zip:

Incident involves: ❑ Patient ❑ Provider ❑ Other

Patient Information

Patient Name:	
DOB:	Sex: ❑ M ❑ F

Patient Social Security/Medicare/Medicaid Number:

❑ Medicare ❑ Medicaid ❑ Commercial ❑ FHK ❑ Other _____

Name of Health Plan:	
Primary Care Physician:	
Patient Phone:	

Provider Information:

Name:

Clinic/Facility Name:

Address:

Patient Admission/Original Diagnosis:

Description of Incident (attach additional documentation as necessary):

Incident Information:

Time:	Date:

Location:

Hospitalization Required? ❑ Yes ❑ No	
Physician Called: ❑ Yes ❑ No	
Name of Physician:	
Statement of treatment and recommendations (attach additional pages or records as needed):	
Facility Name:	Phone:
Address	
Admission Date:	Admission Time:
Employee Involved in Identifying Incident:	
Name:	Phone:
Address:	
Witnesses:	
Name:	Phone:
Address:	
Name:	Phone:
Address:	
Name:	Phone:
Address:	
Initial Corrective Action Taken:	
Signature:	
Print Name:	
Position:	
Date:	